STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from 10/5/17 through 10/12/17. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 49. The Stage 2 survey sample size was 29. Abbreviations / definitions in this report are as follows: Anxiety - unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; Ativan - a medication used to treat anxiety disorders; BID - twice a day; CNA - Certified Nurse's Aide; Dementia - persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; DON - Director of Nursing; ED - Executive Director; eMAR - electronic Medication Administration Record - list of daily medications to be administered; Fentanyl - medication used to treat pain; Hyperlink - a word, phrase, or image that you can click on to jump to a new document or a new section within the current document; LPN - Licensed Practical Nurse; MD - Medical Doctor;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; MRSA - Methicillin-Resistant Staphylococcus Aureus - infection caused by a type of bacteria that has become resistant to many antibiotics; POA - Power of Attorney - resident's representative appointed to make decisions on their behalf; PRN - as needed; Psychopharmacological - medications used to treat mental disorders; RN - Registered Nurse; SW - Social Worker; Serotonin Syndrome - a potential life-threatening condition and symptoms include agitation, restlessness, confusion, rapid heart rate and high blood pressure; TB - tuberculosis or tubercle bacillus; a serious infectious disease that affects the lungs; Timoptic Eye Drops - medication used to treat high pressure inside the eye due to glaucoma or other eye diseases; Trusopt Eye Drops - medication used to treat high pressure inside the eye due to glaucoma or other eye diseases; Vitamin D- vitamin which is essential for strong bones; Zoloft - (sertraline) medication used to treat depression, obsessive-compulsive disorder and panic and anxiety disorder; Zyvox - also called Linezolid / antibiotic medication.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 157		11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews and review of facility documentation, it was determined that for 1 (R37) out of 29 Stage 2 sampled residents, the facility failed to notify the resident's representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention. For R37, the facility failed to notify the POA on 8/26/17 of skin integrity alterations. Findings include: The facility's policy entitled, Resident Condition Changes that Require Physician Notification Guidelines, last revised on 8/7/15, stated, "...Expectations: ...2. Documentation of the resident condition change and proper notification shall be the responsibility of the nurse who observes and assesses the change...4. The licensed nurse shall also notify the: ...Resident and/or family...". Review of R37's clinical record revealed the following: On 8/26/17 at 6:30 PM, the facility's incident report form stated that during the removal of a Fentanyl medication patch on R37's left upper chest, the top layer of skin came off in two places and were noted to be pink in color. The facility's incident report stated that R37's POA was notified the following day, 8/27/17, at 11:45 AM when the two areas changed and they were noted to be	F 157	1. Resident #37 expired on 9/14/17. 2. All residents have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. All licensed nursing staff will be in-serviced by the Director of Nursing/designee about proper notifications of accidents/changes in conditions. 4. The Director of Nursing/designee will audit all new incident reports for proper notifications daily x 5 days for 2 weeks then weekly x 4 weeks. Results of the audits will be brought to the QAPI Meeting for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 red. During an interview on 10/11/17 at 2:06 PM, E6 (LPN) stated that she was the nurse that removed the Fentanyl patch, which accidentally caused two areas of skin to be removed. E6 stated that she contacted the physician after it occurred and there were no new orders given. E6 stated when she returned to work the following day on 8/27/17, she observed the two areas of R37's skin on her left upper chest to be red. E6 stated that it was at this time when she notified R37's POA. Findings were reviewed with E2 (DON) on 10/12/17 at 10:52 PM. The facility failed to notify the R37's POA of a skin alteration on 8/26/17.	F 157		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that 3 [506, 703, 706] out of 50 resident rooms were maintained to be free from disrepair. Findings include: Inspection of resident rooms on 10/10/17 from 10 AM to 11:30 AM with E4 (Director of Environmental Services) during the environmental tour revealed the following: 1. bathroom cold and hot water faucets in room 506 were loose; 2. base of bathroom hot water faucet in room	F 253	1.The maintenance issues identified in rooms 506, 703, and 706 were immediately addressed on 10/10/17. 2.All rooms have the potential to have similar environmental issues. All resident rooms have been inspected by the Director of Maintenance/designee to ensure all rooms are sanitary, safe and orderly. 3.The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. Maintenance staff will receive in-service education, provided by the Director of	11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 703 leaked when the hot water faucet was turned on; toilet seat was loose; 3. water dripped from the bathroom hot water faucet in room 706 when the hot water faucet was turned off; a large patch of peeled paint was found on the bathroom door by the door knob. These observations were confirmed with E4 during the environmental tour on 10/10/17 from 10-11:30 AM. Findings were reviewed with E1 (ED) and E2 (DON) on 10/12/17 at 4:30 PM.	F 253	Maintenance, on identifying and correcting deficient occurrences in resident rooms. 4.The Director of Maintenance or designee will conduct audits of all rooms weekly for 6 weeks to ensure compliance and thereafter will conduct audits randomly. Results will be reported to the QAPI Meeting for follow-up as needed.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280		11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to include the resident and/or resident's POA in care planning and treatment decisions for one (R82) out of 29 Stage 2 sampled residents. Findings include: Review of R82's clinical record revealed: R82 was admitted to the facility on 7/14/17 with diagnoses that included dementia. The 7/21/17 admission MDS assessment stated R82's daily decision making skills were moderately impaired. During a family interview on 10/6/17 at 10:32 AM, F1 (R82's POA) was asked the question, "Do staff include you in decisions about (R82's name) medicine, therapy, or other treatments?" F1 responded, "No." F1 stated that he has never been invited to or attended a care plan meeting. During an interview on 10/9/17 at 3:48 PM, when	F 280	1. R82 remains a resident of the facility. 2. Care Plan invitation has been sent to the family member of R82. All residents have the potential to be effected by this deficient practice. All resident's Care Plans/Care Conferences have been reviewed and any issues have been addressed. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. The Social Services Director has been in-serviced by the Director of Nursing/designee on sending care plan invitations to residents/POA and Interdisciplinary Team members and proper documentation of resident's Care Plan meetings. The facility will send Care Plan invitations as outlined. 4. The Director of Nursing/designee will conduct audits weekly on Care Plan Meetings to ensure completeness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 asked about evidence of care plan meetings, E11 (SW) stated that in the social service section in the hard copy chart there would be a care plan form, and in the progress notes section in the electronic chart there would be an IDT (Interdisciplinary Team) note. E11 stated that for residents who are long term care, care plan meetings are held every 3 months and for short term rehabilitation patients a care plan meeting is held within the first 14 days and then when discharge planning is in progress. E11 also stated that care plan meetings can be held more frequently as needed. E11 stated that letters are sent to the family with the date and time of the scheduled care plan meeting and if the family attends, they will sign in on the form. E11 stated that if the family does not attend that would be noted. During an interview on 10/11/17 at 3:18 PM, E11 stated that R82's POA had been in the facility one day and had questions. E11 stated a care plan meeting had been scheduled for the following week, but it was decided to hold the care plan meeting that day with the POA, instead of the following week and that the therapy department had participated. Review of R82's hard copy chart revealed no evidence of any care plan meeting forms. Review of the electronic record progress notes lacked evidence of any IDT notes regarding a care plan meeting. On 10/11/17 at approximately 3:35 PM, findings were reviewed with E2 (DON).	F 280	including invitations to residents/POA and IDT Members, and documentation of participation weekly x 4 weeks, then monthly x 2 months. Results will be brought to QAPI Meeting for review.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews and review of other facility documentation, it was determined that for 1 (R14) out of 29 Stage 2 sampled residents, the facility failed to provide services that met professional standards of quality. For R14, the facility failed to accurately account for 3 doses of her Zyvox medication, an antibiotic, on her September 2017 eMAR when 3 licensed nurses signed off that the medication was given, despite the medication not being available in the facility. Findings include: Cross refer to F333 Review of R14's clinical record revealed the following: 9/8/17 at 8:17 PM - An electronic physician's order stated to give Zyvox medication two times a day for pneumonia at 9 AM and 8 PM. 9/9/17 at 3:30 PM - R14 was readmitted to the facility with a diagnosis of MRSA pneumonia [lung infection]. 9/9/17 at 8 PM - Review of R14's September 2017 eMAR revealed that one dose of Zyvox was signed off as administered by E9 (RN).	F 281	1. R14 remains a resident of the facility. R14 is no longer receiving Zyvox. Licensed staff E10, E7, E 9 have been in-serviced by the Director of Nursing/designee on documentation of medications that have not been administered. 2. All residents have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. All residents medical records have been reviewed and no further infractions were noted. All licensed nursing staff will be in-serviced by the Director of Nursing/designee on medication administration/documentation. All new residents admissions/all new orders will be reviewed daily in the Clinical Meeting to ensure completeness and accuracy and availability of prescribed medications. 4. The Director of Nursing/designee will audit all resident MARs weekly x 4 weeks for accuracy and then every 2 weeks for 1 month. Audit results will be brought to the QAPI Meeting and reviewed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10 9/10/17 at 10:45 AM - An electronic physician's order stated to administer Zyvox when it becomes available through the facility's pharmacy. 9/10/17 at 1:26 PM - The daily skilled nurse's note stated that the facility was currently waiting for R14's Zyvox to be delivered from the pharmacy. Review of R14's September 2017 eMAR revealed the following: - 9/10/17 at 8 PM - one dose of Zyvox was signed as administered off by E10 (RN); - 9/11/17 at 9 AM - one dose of Zyvox was signed as administered off by E7 (LPN). 9/11/17 timed 8:38 PM - Review of the pharmacy's prescriptions delivery sheet revealed that R14's Zyvox medication was not received by the facility until the evening of 9/11/17. It was unclear as to why 3 different licensed nurses signed on R14's eMAR that R14 received her antibiotic, Zyvox, when in fact the medication was not available in the facility. Review of R14's progress notes during the 3 shifts (9/9/17 evening shift, 9/10/17 evening shift and 9/11/17 day shift) lacked evidence of any Zyvox medication issues. During an interview on 10/12/17 at 1:48 PM, E9 confirmed that she did not administer Zyvox on 9/9/17 at 8 PM, despite the fact that she signed off the Zyvox medication as administered on R14's September 2017 eMAR. During an interview on 10/12/17 at 1:50 PM, E2 (DON) stated that the facility does not keep Zyvox in the emergency back-up medication supply. E2	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 also stated that the pharmacy delivers medications twice a day at 3 PM and 8 PM. Findings were confirmed with E2. The facility failed to provide services that met professional standards of quality when 3 licensed nurses signed off 3 doses of R14's antibiotic medication, Zyvox, as administered on the September 2017 eMAR, despite the medication not being available in the facility.	F 281		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R82) out of 27 Stage 2 sampled residents, who was unable to carry out activities of daily living, received the necessary services to maintain grooming and personal hygiene. Findings include: Review of R82's clinical record revealed: R82 was admitted to the facility on 7/14/17 with diagnoses that included dementia. The admission MDS assessment, dated 7/21/17, stated R82's daily decision making skills were moderately impaired and that extensive assist of one staff was required for transfers and bathing. Review of the facility's "Resident Bath Schedule" revealed that based on R82's room number,	F 312	1. R82 remains a resident of the facility. R82 has received a documented shower (in the medical record.)R82 shower schedule has been fixed in the electronic medical records to indicate proper shower days. 2. All residents have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. All residents medical records have been reviewed and shower documentation section corrected and active for proper documentation. The Electronic Medical Record has been fixed to prompt the caregiver to document showers when given. All nursing staff have been in-serviced on proper ADL documentation	11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 12 showers were to be given on Mondays and Thursday on the 3 PM to 11 PM shift. Review of CNA's electronic documentation survey report from 8/18/17 through 8/31/17 for "Bathing/Showers" revealed the following: - There was no documented evidence on Monday and Thursday evenings that any showers had been provided; - Review of the documentation revealed that staff were documenting under bathing/showers on Tuesday and Friday day shift (7 AM - 3 PM) that R82 required extensive to total assist of one staff, however it did not identify if an actual shower was given; - Review of the documentation also revealed that on seven (7) occasions it stated "NA" (Not Applicable), signifying a shower had not been given. During an interview on 10/11/17 at 3:26 PM, E12 (CNA) stated that at the start of her shift (3 PM to 11 PM) she first completes rounds on all her assigned residents and then she checks the book for the bath schedule. E12 stated that when a shower is given it is documented in the electronic record under bathing/shower. Findings were reviewed with E2 (DON) during an interview on 10/9/17 at approximately 3:35 PM.	F 312	by the Director of Nursing/designee. 4. The Director of Nursing/designee will audit 15 resident's medical records weekly x 4 weeks to ensure proper shower documentation. Result of audits will be brought to the QAPI meeting for review.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews and review of facility documentation, it was determined that for 2 (R16 and R13) out of 29 Stage 2 sampled residents, the facility failed to ensure that each resident's drug regimen was	F 329	1. (a) R16 remains a resident of the facility. R16 was evaluated by a Psychiatrist on 10/18/17. R16 is given prn Ativan only after behavioral interventions are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14 free from unnecessary drugs. For R16, the facility failed to try non-pharmacological interventions prior to medicating R16 with PRN Ativan, an anti-anxiety medication, on 6 occasions from 9/1/17 through 10/8/17. For R13, the facility failed to monitor her Vitamin D level. Findings include: 1. The facility's policy entitled, Psychopharmacological Medication, last revised on 4/9/07, stated, "...The facility should, through observation, report and consultation with the prescribing physician, work to ensure that prior to the use of any psychopharmacological...medications, the following criteria are met:...Non pharmacological interventions have been tried prior to the use of the medication (including behavior interventions) examples of non-pharmacological interventions include but are not limited to: a. Identifying addressing and eliminating or reducing underlying causes of Distressed Behavior such as boredom and pain. b. Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of life long work or activity patterns.... c. Developing interventions that are specific to resident's interests, abilities, strengths and needs...". Review of R16's clinical record revealed the following: R16 had a diagnosis of anxiety. According to the September 2017 eMAR, R16 received PRN Ativan on the following dates: - 9/2/17 at 3:48 PM; - 9/4/17 at 2:27 PM; - 9/15/17 at 7:12 PM; - 9/30/17 at 4:27 AM.	F 329	attempted, the need for the medication documented on the Behavioral Intervention Flow Record and the results of the administration of the medication is documented. (b) R13 Vitamin D levels have been drawn and reviewed by the Medical Director and is within normal limits. 2. (a) All residents with psychotropic medications have the potential to be effected by this deficient practice. Residents receiving pharmacological interventions have been audited for the existence of non-pharmacological nursing interventions prior to receiving medication, documentation of the need for medication in the Behavioral Intervention Flow Record and that the results of the medication□s administration is documented. Nursing staff have been in-serviced by the Director of Nursing/designee about the necessity to initiate non-pharmacological interventions prior to the administration of psychotropic medication, as well as documenting the results of the medication. (b) All residents receiving Vitamin D have the potential to be effected by this deficient practice. All residents receiving Vitamin D have been audited to ensure that a current Vitamin D level test has been drawn. 3.(a)The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. Licensed Nursing staff were in-serviced by the Director of Nursing/designee on using	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15 Review of R16's September 2017 eMAR and Progress Notes revealed a lack of evidence of non-pharmacological interventions attempted prior to medicating R16 with PRN Ativan on 9/2/17, 9/4/17, 9/15/17 and 9/30/17. According to the October 1-8, 2017 eMAR, R16 received PRN Ativan on the following dates: - 10/5/17 at 9:45 AM; - 10/8/17 at 7:28 PM. Review of R16's October 2017 eMAR and Progress Notes revealed a lack of evidence of non-pharmacological interventions attempted prior to medicating R16 with PRN Ativan on 10/5/17 and 10/8/17. Finding were reviewed with E2 (DON) on 10/12/17 at 10:49 AM. The facility failed to attempt non-pharmacological interventions prior to medicating R16 with PRN Ativan on 6 occasions. 2. Review of R13's clinical record revealed the following: 1/21/15 - R13's original physician's order for Vitamin D3 (oral supplement form of Vitamin D) 1,000 Unit tablet 2 tablets (2,000 Units) to be administered every day. Review of R13's laboratory blood tests lacked evidence that any monitoring of Vitamin D levels was completed. The facility failed to ensure that monitoring of blood levels was completed for Vitamin D levels for R13 who has been receiving the supplement	F 329	non-pharmacological interventions prior to the use of prn psychotropic medication and documentation of this and the documentation of the results. (b) For R13, the facility failed to obtain periodic blood tests for Vitamin D levels. Licensed Nursing staff were in-serviced by the Director of Nursing/designee about obtaining periodic blood tests for residents receiving Vitamin D. The Consulting Pharmacist was in-serviced by the DON about the need to recognize necessary blood testing relative to Vitamin D. 4. (a)The Director of Nursing or designee will audit all residents who receive prn psychotropic medication monthly for three months to ensure compliance with non-pharmacological interventions and documentation. Audit results will be reported to the QAPI Meeting for follow-up as needed. (b)The Director of Nursing or designee will audit all residents who receive Vitamin D monthly for four months to ensure periodic blood testing. Audit results will be reported to the QAPI Meeting for follow-up as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 16 since January 2015. 10/9/17 at approximately 3:35 PM - Findings were reviewed with E2 (DON).	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that their medication (med) error rate was not 5 percent (%) or greater. The facility med error rate was 10.7%. Findings include: Med pass observations on 10/5/17 in the 500 hall revealed the following: 1. At 8:50 AM, E3 (LPN) incorrectly administered R57's Lacri Lube (also known as Lubricant eye ointment and Artificial Tear eye ointment) eye ointment to both eyes. The physician's order, dated 8/27/17, stated to give Lacri Lube in the right eye four times a day. There was not a physician's order to administer Lacri Lube ointment to the left eye. Findings were reviewed and confirmed with E3 on 10/5/17 at approximately 1 PM. Med pass observations on 10/11/17 in the 600 hall revealed the following:	F 332	1. R57 remains a resident of the facility. R51 has been discharged from the facility. 2. All residents receiving eye drops have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. All licensed nursing staff will be in-serviced by the Director of Nursing/designee on administration of ophthalmic medication. 4. The Director of Nursing/designee will audit administration of ophthalmic medication x 4 weeks then randomly weekly x 4 weeks to ensure accuracy. Results of the audits will be brought to QAPI meetings for review.	11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 17 2 a. At 8:15 AM, E7 (LPN) incorrectly administered R51's Timolol Maleate (also known as Timoptic) eye drops to both eyes. The physician's order, dated 9/15/17, stated to give one (1) drop in each eye two times a day. There was a pharmacy note attached to the order that stated to wait 10 minutes between eye meds. Manufacturer's instructions (Merck) under dosage and administration stated, "...Other topically applied (given directly onto the eye) ophthalmic (eye) medications should be administered at least 10 minutes before Timoptic...". The times listed on the eMAR were 9:05 AM and 8:10 PM. Timoptic was being given for glaucoma; a group of eye conditions that damage the optic nerve, which can cause blindness. This damage is often caused by an abnormally high pressure in eye(s). 2 b. At 8:16 AM, E7 incorrectly administered R51's Trusopt (also known as Dorzolamide HCL) eye drops to both eyes. The physician's order, dated 9/15/17, stated to give one (1) drop in each eye two times a day. There was a pharmacy note attached to the order that stated to wait 10 minutes between eye meds. Manufacturer's instructions (Merck) under dosage and administration stated, "...If more than one topical opthalmic drug is being used, the drugs should be administered at least 5 minutes apart." The times listed on the eMAR were 9:00 AM and 8:00 PM. Trusopt was being given for glaucoma. Findings were reviewed and confirmed by E7 on 10/11/17 at approximately 2 PM. The facility failed to administer eye medication to R57 as ordered and for R51, they failed to administer glaucoma medications as per the pharmacist's and manufacturer's instructions for	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 18 timing between eye drops.	F 332		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for 1 (R14) out of 29 Stage 2 sampled residents, the facility failed to ensure that a resident was free of any significant medication errors. For R14, the facility failed to correctly enter a 9/10/17 electronic physician's order to hold Zoloft, an anti-depressant medication, until R14 completed her Zyvox medication, an antibiotic, which had the potential to cause a severe medication interaction. R14 was administered Zoloft on 9/11/17. Findings include: Review of R14's clinical record revealed the following: 9/8/17 at 8:17 PM - An electronic physician's order stated to give Zyvox medication two times a day for pneumonia at 9 AM and 8 PM. 9/8/17 at 8:45 PM - An electronic physician's order stated to give Zoloft medication one time a day for depression at 9 AM. Further review of the physician's order revealed the following hyperlink from the pharmacy that stated, "ALERT! Drug Interaction".	F 333	1. R14 remains a resident of the facility. R14 is no longer taking Zyvox but remains on Zoloft. 2. All residents taking medications have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. R14 was evaluated by the facility's psychiatrist on 10/12/17. All resident medical records have been reviewed and no drug interaction issues were noted. All new admissions and orders will be reviewed daily at Clinical Meeting for ALERT! Drug Interaction and proper pharmaceutical recommendations followed. All licensed nursing staff will be in-serviced by Director of Nursing/designee on transcription of medication orders on electronic medical records. 4. The Director of Nursing/designee will audit all orders daily at the clinical meeting to ensure proper transcription on the electronic medical records x 2 months. Results of the audits will be brought to	11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 19 9/9/17 at 3:30 PM - R14 was readmitted to the facility with a diagnosis of MRSA pneumonia. 9/10/17 at 9 AM - Review of R14's September 2017 eMAR revealed that her Zoloft medication stated "5", which meant that the medication was held and referred to progress notes. 9/10/17 at 10:45 AM - An electronic physician's order stated to administer Zyvox when it becomes available through the facility's pharmacy. 9/10/17 at 11:19 AM - An electronic physician's order stated to hold Zoloft until the Zyvox medication was completed due to a severe interaction between the medications. 9/10/17 at 1:26 PM - The daily skilled nurse's note stated, "...linezolid (Zyvox)...bid. currently waiting on arrival of medicine from pharmacy. MD notified. order in place for may administer linezolid once available through pharmacy...". 9/11/17 at 9 AM - Review of R14's September 2017 eMAR revealed that Zoloft medication was administered to R14. The facility failed to hold R14's Zoloft medication as per a 9/10/17 physician's order. 9/11/17 at 11:36 AM - The original physician's order, dated 9/8/17, for Zyvox medication two times a day for pneumonia was discontinued and a new electronic physician's order was entered and stated to give Zyvox two times a day for pneumonia for 8 administrations. Further review of the physician's order revealed a hyperlink from the pharmacy that stated "ALERT! Drug Interaction". The ALERT stated, "Drug-to-Drug	F 333	QAPI Meetings for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 20 Interaction Details...Coadministration of Sertraline (Zoloft)...and Linezolid (Zyvox)...may cause central nervous system toxicity characterized by symptoms of serotonin syndrome. Initiation of Sertraline...in patients receiving Linezolid...is contraindicated according to official package labeling." 9/11/17 at 11:37 AM - R14's electronic physician's order for Zoloft, dated 9/8/17, was modified and a hold was ordered and effective starting 9/11/17 at 11:37 AM due to an interaction with Zyvox. 9/11/17 at approximately. 8 PM - Review of the September 2017 eMAR revealed that R14 refused to take her Zyvox medication when the licensed nurse attempted to administer the medication. During an interview on 10/12/17 at 1:49 PM, findings were confirmed with E2 (DON). E2 confirmed that R14's Zoloft medication was to be held, but the 9/10/17 electronic physician's order was not entered correctly in the September 2017 eMAR. The facility failed to ensure the 9/10/17 electronic physician's order to hold Zoloft until R14 completed her Zyvox medication was followed, which had the potential to cause a severe medication interaction. R14 was administered Zoloft on 9/11/17.	F 333		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		11/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the safe and sanitary handling of clean dishes and utensils to prevent the contamination of food. Findings include: During a follow-up visit to the kitchen on 10/10/17 at 12:15 PM, E5 (Dishwasher) was observed preparing and handling soiled dishes and utensils for dishwashing with his bare hands. E5 then moved each rack containing the dirty dishes and utensils into the dishwasher. When the first rack came out of the dishwasher, E5 put on a right-handed glove and removed each cleaned item from the rack, assisted in part by his bare left hand that had handled dirty dinnerware.	F 371	1.The dietary department issues identified were immediately addressed.E5 has received education on correct preparing and handling of soiled dishes and utensils. 2.The Dietary Department has the potential to have similar sanitation and hygiene issues. 3.The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. Dietary Utility staff were in-serviced by the Assistant Food Service Director on sanitary handling of dishware and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 In a review of these observations on 10/12/17 at 3 PM, E1 (ED) stated that the Food Service Director had placed a set of gloves in the dish room to use for cleaned items, instead of using bare hands. Findings were reviewed with E1 and E2 (DON) on 10/12/17 at 4:30 PM.	F 371	utensils. 4. The Executive Chef or designee will conduct audits of dish washing/utensils weekly x 4 weeks then every 2 weeks x 2 months. Results will be reported to the QAPI Meeting for follow-up as needed.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		12/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 441	1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 facility documents, it was determined that the facility failed to ensure that a two-step TB test was completed on 1 [E8} out of 5 sampled employees hired since June 1, 2017. Additionally, the facility failed to have proper hand hygiene (handwashing) for one employee after direct resident contact during medication pass observations. Findings include: Review of the facility's Tuberculosis Polices CL-HHA-5.7, dated 11/15/10, stated, "All direct contact staff will be tested for tuberculosis (TB) exposure annually". 1. Review of employee records for E8 (Cook), hired 6/12/17, revealed no documentation of a two-step TB test as required per the facility policy and new hire documents. During an interview with E1 (NHA) on 10/9/17 at approximately 11 AM, E1 stated that E8 was pregnant at the time of hire, therefore no TB testing was done. Review of the Center for Disease Control (CDC) guidelines for TB testing stated: "the tuberculin skin test is considered both valid and safe to use throughout pregnancy". During an interview with E2 (DON) on 10/11/17 at approximately 1:30 PM, E2 confirmed findings. The facility failed to maintain their own Infection Prevention Control Program by allowing E8 who did not have a TB test to start working at the facility on 6/12/17.	F 441	1. (a) E8 is no longer employed by the facility. All health care personnel files have been audited and TB testing is up-to-date. 2. All new hired health care employees have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. The Executive Director/designee will in-service the Human Resources Director on proper TB testing of new hires prior to starting work. 4. The HR Manager/designee will audit new hire personnel files every 2 weeks x 2 months. Audit results will be brought to QAPI meeting for review. 2. 1. E3 has been in-serviced on proper hand-washing by the Director of Nursing/designee on 10/18/17. 2. All employees have the potential to be effected by this deficient practice. 3. The facility conducted a root cause analysis and results will be discussed at QAPI for further recommendations. All staff will be in-serviced by the Director of Nursing/designee on proper hand-washing and infection control policy. 4. The Director of Nursing/designee will conduct random audits of 6 employees per week x 2 months to ensure proper hand-washing and infection control.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 2. Review of the facility policy and procedure, dated 1/1/01 and entitled Handwashing, stated, "...Handwashing is the most important component for preventing the spread of infection... PROCEDURE 1. Handwashing is performed... b. Before and after resident contact... METHOD/STEPS... f. Turn water off using a dry paper towel (prevents hands from becoming recontaminated)...". During the medication pass on 10/5/17, E3 (LPN) was observed washing her hands and then turning the faucets off with her bare hands (thus, recontaminating them) after administering medications to: a. R13 at 8:45 AM. b. R57 at 8:54 AM. Findings were reviewed and confirmed with E3 on 10/5/17 at approximately 1 PM.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

FACILITY NAME: Shipley Manor Health Care Nursing Home DATE SURVEY COMPLETED: November 1, 2017

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES (PoC)	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** A desk review complaint investigation survey was conducted from October 20, 2017 through November 1, 2017 regarding this facility. The deficiency contained in this report is based on interview and review of the facility's Admission Agreement. Definition used in this report is listed below: Fiduciary Party- An individual, corporation or association holding assets for another party, often with the legal authority and duty to make decisions regarding financial matters on behalf of the other party. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on November 1, 2017: F208	Answer to complaint investigation has been submitted through e-POC. 11-17-17 Cross Reference CMS 2567-L	11-17-17

Provider's Signature [signature] **Title** NHA **Date** 11-2-17